APPENDIX C: SCREENING AND DOCUMENTATION FORMS

APPENDIX C: SCREENING AND DOCUMENTATION FORMS

Domestic Violence Screening/ Documentation Tool **Name.**

ID #:

Screening Question

Because violence is so common in our community, I now ask all patients: **Date:**

Yes___ No___ Are you in a relationship in which you have been hurt, or threatened?

Yes___ No___ Have you ever been hit, punched or kicked by someone close to you?

Document your findings

Victim's statement (Description of the assault):

_____
_____
_____
_____

Yes ___ No ___ Abuse Suspected, but denied by victim? State reasons:

_____
_____
_____

Yes ___ No ___ Abuse Confirmed by victim? If yes, document name and relationship of abuser:_____

Assess Victim's Safety

Yes ___ No ___ Is the abuser here now?

Yes ___ No ___ Are you afraid to go home?

Yes ___ No ___ Has your partner injured any pets?

Yes ___ No ___ Are you pregnant?

Yes ___ No ___ Have you ever been forced to have sex?

Yes ___ No ___ Are there children in you home? Their ages?_____

Yes ___ No ___ Has your partner been violent toward the children?

Yes ___ No ___ Does your partner abuse alcohol or drugs?

Yes ___ No ___ Is there a gun in the house?

Yes ___ No ___ Do you need immediate shelter? Yes ___ No ___ Hot Line number given?

Yes ___ No ___ Call placed? Yes ___ No ___ Brochure given?

Yes ___ No ___ n/a ___ Police notified? Dept: _____

Yes ___ No ___ n/a ___ De. Children Family Services contacted @ 800-292-9582

Yes ___ No ___ n/a ___ De. Adult Protective Service contacted@ 800-223-9074

Yes ___ No ___ n/a __ Rape Crisis-Contact of Delaware @ 800-262-9800

Yes ___ No___ n/a ___ Photographs taken? Yes ___ No ___ Consent signed?

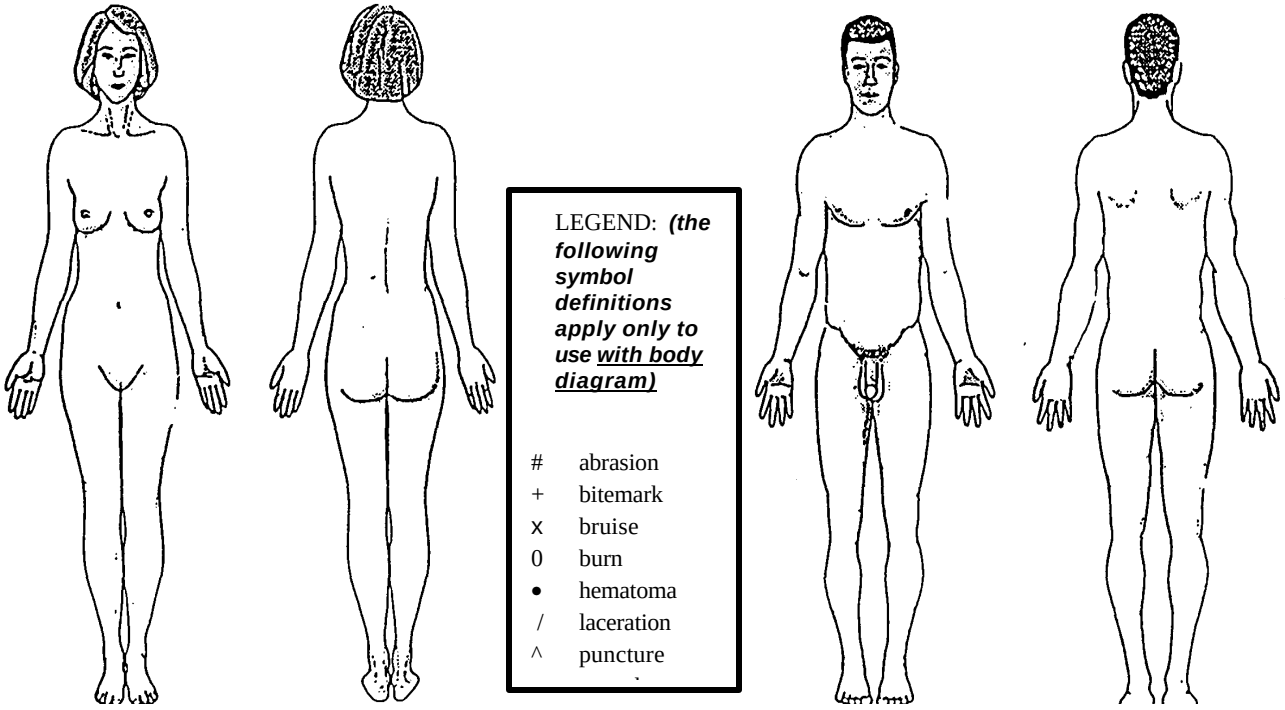
Yes ___ No___ n/a ___ Photos given to police? Yes ___ No ___ Photos with Chart?

Name/Title (print)
_____Date_____

Hot Line Referral: NCC # (302) 762-6110 Kent/Sussex Co. # (302) 422-8058

Domestic Violence is also called spouse or partner abuse and battering. It is a subset of a larger term called family violence, which includes child and elder abuse, and is now considered to be a "silent epidemic." Therefore, it is important and helpful to ask questions about abuse. Victims may not respond immediately, but you have begun the process of developing trust. Maintain eye contact and remain empathic - most abuse victims are filled with fear and shame. Communicate to the victim of abuse that:

S/he is not alone,
This is not her/his fault,
No one has the right to hurt her/him,
and Help is available…



LEGEND: ***(the following symbol definitions apply only to use <u>with body diagram</u>)***

#	abrasion
+	bitemark
x	bruise
0	burn
•	hematoma
/	laceration
^	puncture

Comments:_____
_____
_____
_____
_____

Print Name: _____ Date:
_____

Consent for Photography

Photographs will be taken and maintained with your medical record and/or sent with evidence to the police.

Patient: _____ Date: _____ Witness: _____

Hot-Line Numbers

	Child Abuse	Domestic Violence
New Jersey .....Salem County	1-800-792-8610	1-856-935-6655
Maryland .....Cecil County	1-410-996-0100	1-410-996-0333
Pennsylvania .....Delaware County	1-610-713-2000	1-610-565-4590
…….Chester County	1-610-344-5800	1-610-431-1430

DOMESTIC VIOLENCE ABUSE ASSESSMENT

Date_____ Client ID#_____

Client Name_____

Client Pregnant ___yes ___no

R=ROUTINELY SCREEN
Because violence is so common in women's lives, I've begun to ask about it routinely.

A=ASK DIRECT QUESTIONS

___yes ___no Do you feel safe at home?
___yes ___no Are you in a relationship in which you have been hurt or threatened?
___yes ___no Have you ever been hit, kicked, or punched by someone close to you? _____ # of times in past yr.
___yes ___no I notice you have a number of bruises; did someone do this to you?

D=DOCUMENT YOUR FINDINGS

Client Report (Use Client's Own Words) - Client Description of Assault (struck with fists or object, kicked, thrown, etc.)

_____
_____
_____
_____
_____
_____
_____
_____

___yes ___no **Abuse Confirmed.**
If yes, name of alleged perpetrator and relationship to client:

_____
_____

___yes ___no **Abuse Suspected. State reasons.**

_____
_____
_____
_____

A=ASSESS CLIENT SAFETY

___yes ___no Is client afraid to go home?
___yes ___no Increase in severity/frequency of abuse?
___yes ___no Threats of homocide or suicide?
___yes ___no Weapon present?

R=REVIEW OPTIONS AND REFERRALS

___yes ___no Need immediate shelter?
___yes ___no Hotline numbers/community resources given?
_____
___yes ___no Referred to CHC staff?
_____
___yes ___no Referred to outside source?
_____
___yes ___no Follow-up appointment made? _____date
___yes ___no Can client be called at home? If no, is there a safe number where client can be reached?
_____

Provider Evaluation

_____
_____
_____
_____
_____

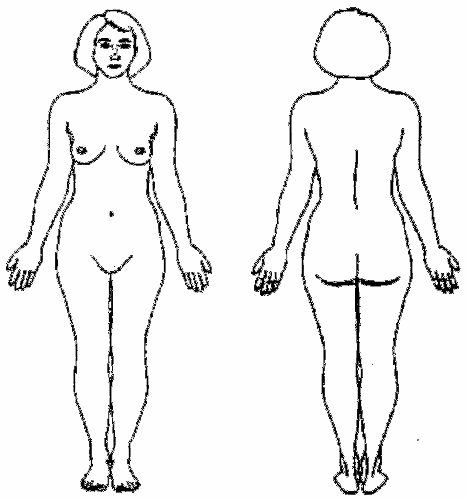
Provider Signature_____

Check Physical Findings

	Contusion	Abrasion	Laceration	Bleeding	Tenderness
Head					
Ears					
Nose					
Cheeks					
Mouth					
Neck					
Shoulder					
Arms					
Hands					
Chest					
Back					
Abdomen					
Genitals					
Buttocks					
Legs					
Feet					

___yes ___no Photographs taken?

Indicate Where Injury Was Observed:



Philadelphia Family Violence Working Group 215/765-8703

W V H C S - HOSPITAL, INC.	NAME
ED NURSING CARE RECORD WBGH Campus	ED #
	MR #
	AGE PMD
	Was the PMD called by the patient prior to coming to ED? ☐ Yes ☐ No
FORM # 700.027.94 BARCODES / OCR #	

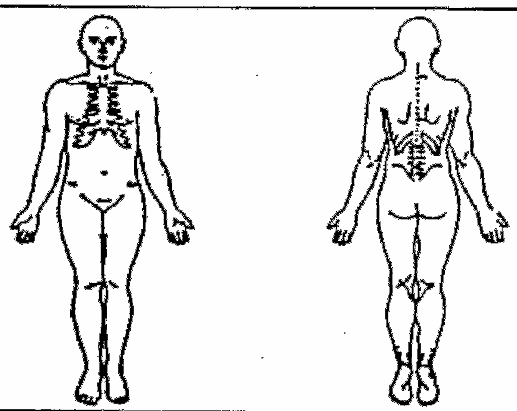
TRIAGE CLASSIFICATION	☐Emergent I ☐Urgent II ☐Non-Urgent III	VITAL SIGNS	T P R BP /	Pulse Oximetry	% O_2 at
REASON FOR VISIT	☐Trauma ☐Surgical ☐Medical ☐Psycho / Social ☐OB-/ Gyn -	ARRIVED WITH	☐Spouse ☐Son / Daughter ☐Parent ☐Friend ☐Police ☐ Self ☐Other_____		
MODE OF ARRIVAL	☐Ambulance Name _____ ☐Ambulatory ☐Wheelchair ☐ Carried ☐ Other				
TREATMENT PRIOR TO ARRIVAL					
CHIEF COMPLAINT / ONSET OF SYMPTOMS	DOMESTIC VIOLENCE ☐Yes ☐No				
NURSING COMMENTS/ACTION	R.N.				
PAST MEDICAL HISTORY					
PRESENT MEDICATIONS					
ALLERGIES					
LAST TETANUS		KNOWN DISABILITIES			

S SUBJECTIVE: History of present illness

O OBJECTIVE

Coma Scale		Skin:	Respirations:		Additional Objective Observations:
Eye Opening	Spontaneous - 4	COLOR	Normal ☐	Rapid ☐	
	To Speech/Sound - 3	Cyanotic ☐	Shallow ☐	Slow ☐	
	To Pain (in limbs) - 2	Ashen ☐	Deep ☐	Labored ☐	
	None - 1	Pale ☐	Apneic ☐		
Best Verbal	Oriented - 5	Normal ☐	Stridor R ☐ L ☐		
	Confused Convers 4	Flushed ☐	Wheezing R ☐ L ☐		
	Inapprop Words - 3	TEMPERATURE	Rales/Ronchi R ☐ L ☐		
	Incomprehensible - 2	Hot ☐	Diminished R ☐ L ☐		
	None - 1	Warm ☐	Clear R ☐ L ☐		
Best Motor	Obeys Command - 6	Cool ☐			
	Localizes Pain - 5	Cold ☐			
	Withdraws to Pain - 4	CONDITION			
	Flexion to Pain - 3	Dry ☐			
	Extension to Pain - 2	Damp ☐			
	None - 1	Wet ☐			

A = Abrasion
B = Amputation
C = Burn (Specify)
D = Contusion
E = Closed Deformity
F = Open Deformity
G = Ecchymosis
H = Edema / Swelling
I = Laceration
J = Pain
K = Scars
L = Gunshot Wound
M = Stabwound



A ASSESSMENT Nursing Diagnosis

P PLAN:

Nurse Signature

CONSENT TO PHOTOGRAPH

(In the event a photograph is taken, be sure to compte this form including the patients signature.)

The undersigned hereby authorizes _____
(Name of Agency)

and the attending physician to photograph or permit other persons in the employ of this facility to photograph _____
(Name of Patient)

while under the care of this facility, and agrees that the negatives or prints be stored in patient's medical record, sealed in a separate envelope, in the event they may be needed later for evidence. These photographs will be released to the police or prosecutor only when the undersigned gives permission to release the medical records. The undersigned does not authorize any other use to be made of these photographs:

Date _____ Patient's Signature _____

Witness _____ _____
Patient's Parent or Legal Guardian

_____
Street Address

_____
City State Zip

Addressograph

Developed by Fulton County Medical Center, McConnellsburg, PA. (McConnellsburg)